Addressing Gynecologic Oncology Geographic Disparities – An Alternative Model for the Delivery of High Quality, Cost-Effective Care in Underserved Rural Areas

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PURPOSE

Rural regions of the United States (U.S.) where greater than 20% of new gynecologic cancers arise, are underserved by gynecologic oncology specialists. Access to quality care for women with gynecologic cancers is limited by uneven distribution of gynecologic oncologists (GOs) across the country and distance to providers. This project was undertaken to develop an alternative model, augmenting the traditional delivery model, to improve access to high quality, cost-effective gynecologic oncology services in rural areas under-represented by GOs.

MATERIALS & METHODS

U.S. census reports and directories of practicing GOs were used to establish the distribution of GOs relative to population density and size of geographic region. PubMed, Medline and Google searches were performed to define the traditional, full-time GO model. The traditional model was then deconstructed into components proven to be associated with benchmark quality clinical outcomes. An alternative model was developed to provide on par clinical outcomes while accommodating the needs of patients in regions that lack the presence of a full-time GO.

RESULTS

An alternative delivery model was developed focusing on quality outcomes based on benchmarks for survival, adherence to National Comprehensive Cancer Network (NCCN) guidelines and quality metrics established by the Quality Oncology Practice Initiative (QOPI) and the Society of Gynecologic Oncology (SGO). Survival and adherence to NCCN guideline are improved when 1) a GO guides or participates in all aspects of gynecologic cancer care, 2) the care is performed by high-volume providers (HVP), and 3) a multidisciplinary team of providers attends to the various aspects of care. Patients in some rural areas of the U.S. do not have equal access to a GO, HVP, or multidisciplinary care team. Therefore, they do not share the benefits of enhanced clinical outcomes. An alternative model was developed for remote regions, centered on a multidisciplinary team of medical and surgical providers organized around a GO who influences all aspects of care by providing surgical proctoring, mentoring, educating, and monitoring of all the team’s activities. The team is composed of the target hospital’s medical staff while the GO is semi-remote. On-site activities of the GO include proctoring in the operating room and participating in clinical conferences as a mentor and source of information for the team of on-site providers. Off-site activities of the GO include 24/7 availability via phone or HIPAA-compliant videoconferencing. Close monitoring and documentation of all activities and continuous quality improvement of the team is a prime role of the GO. Quality metrics established by the QOIP and the SGO as well as adherence to NCCN guidelines are cataloged to compare against institutions using the traditional model. Feasibility and liability issues are addressed. Since the model does not require a full-time GO, the cost would be substantially less.

CONCLUSIONS

An alternative model is proposed to augment the traditional delivery of gynecologic cancer care to increase positive patient outcomes in underserved regions of the U.S. The study model takes quality, cost, and feasibility into account. Further outcomes research is warranted to compare to the traditional model. If used successfully it has the potential to provide quality affordable care to thousands of women who otherwise lack patient-centered access to GO care.